New Mexico Behavioral Health Expert Panel

White Paper Draft

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Purpose of this White Paper

The purpose of this white paper is to present findings and recommendations about the next phase of implementation of New Mexico's behavioral health system based on information gathered from approximately 50 behavioral health experts who gathered in July and August of 2011 for three one-day meetings to discuss and define the evolution and future of behavioral health services and systems in New Mexico.

The information presented in this paper is to be used as a guide for state government leaders, policy makers, consumers, advocates, providers and others working together to ensure better and more integrated behavioral health services for all New Mexicans.

Finally, the requirement for mental health parity approved through the federal Parity Act will dramatically increase the number of insured New Mexico citizens who will be potentially requesting some form of behavioral health coverage.

The Process

Through the leadership of the New Mexico Behavioral Health Collaborative, a process was developed and implemented to assess the current system and make recommendations for the future of behavioral health in New Mexico, taking into account the increasing number of people potentially accessing the system, the federal focus on integrating behavioral health and primary care, and the ongoing reality of limited funds to provide behavioral health services. A **Behavioral Health Task Force**, consisting of behavioral health experts and state personnel, was initially convened by Linda Roebuck Homer, Collaborative CEO, to recommend a process for this system re-assessment. (Please see Appendix A for a list of Task force members and their affiliations.)

At the first and subsequent meetings of the Task Force a number of key decisions were made. A set of core commitments was developed. A set of preliminary guiding questions was developed. A process and timeline for gathering input from relevant and representative stakeholders was outlined. It was agreed that there would be transparency throughout the process. And it was determined that all input would be analyzed and then articulated in a white paper that would serve as a guide for the State and stakeholders in the evolution of new Mexico's behavioral health system.

The Task Force initially affirmed the following core principles and commitments for the future system:

- Protecting and strengthening behavioral health
- Integrating behavioral and physical healthcare for the whole person
- Shaping our future using what we have learned from the past and our vision for the future
- Maintaining focus on recovery and resiliency
- Focusing on individual outcomes and wellness

The Task Force would continue to meet regularly throughout the process to provide support, problem solve and coordinate

The Expert Panel members were divided into four work groups and each group was assigned a color. (Please see Appendix B for a list of Expert Panel members, their affiliations and the constituency group(s) they represent.)

Each Expert Panel member was selected for her/his behavioral health expertise. Expert Panel members are representative of the population of the state, and include consumers and family members, advocates, and youth and adult providers. Attention was paid to ensure that Expert Panel members represented the racial/ethnic and geographic diversity of the state. Lastly, it was an expressed expectation of all Expert Panel members that they would act as liaisons and provide information to, and solicit input from the constituency group(s) that they each represented.

Meetings were scheduled for July 7, July 29, and August 18, 2011

The First Meeting[7] [8]

The first meeting, on July 7th, was designed to provide an overview of the process and information that could be used by Expert Panel members in subsequent meetings as they worked to answer the questions above and make recommendations for the future direction of behavioral health in New Mexico. As such, the following presentations by local and national experts were provided:

- *Overview of the Process and What We are Trying to Accomplish*[9]
  - Linda Roebuck-Homer, CEO, NM Behavioral health Collaborative
- *Medicaid Modernization in NM and Implications for Behavioral Health*[10]

[7] The agenda for the first meeting can be viewed at: https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoZjUwNTgwNzQtZGVlYy00ZjI5LTk2MGQtNTEwYTc2NWRjODFl&hl=en_US.

[8] Notes from the first meeting can be viewed at: http://www.cbhtr.org/bhept

[9] https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoY2ZiNjE5YmYtNjU3ZS00OWZiLWFlYTktMmQ4MGQxODU5MmMy&hl=en_US

The Second Meeting[16] [17]

The Second Meeting was held on July 29th. This meeting was structured to provide Expert Panel members almost an entire day to answer the following questions related to how New Mexico accomplishes integrated care and ensures a strong behavioral health system in New Mexico:

1. Should behavioral health remain carved out, become carved in, or should a hybrid model be developed?
2. How should funding for behavioral health services be administered and/or tracked?
3. What governance structure(s) should be in place given your answers to questions 1 and 2 above?

After a brief welcome and introduction, Expert Panel members were divided into four groups by color – yellow, green, blue and red- and provided a break out room. Each group included consumers, family members, providers and advocates. CBHTR staff facilitated group discussions and scribes captured notes. State agency "experts" rotated through the groups to answer questions. At the end of the day, all Expert Panel members came together to report out and discuss their findings.

Findings and Considerations to Date

It is important to note that what follows are the findings of the authors of this white paper based on a review and analysis of meeting notes from the first and second meetings. There will be an opportunity for Expert Panel members to review these findings and the white paper in its entirety prior to, and during the August 18th meeting, and make corrections as needed.

While there was not consensus across the groups on the answers to these questions, there were a number of "consensus items" that emerged during the wrap up session. These items were

[16] The agenda for the second meeting can be viewed at: https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNTQxMjIxMzgtZmUzZS00ZjQzLWFjNDctN2JlYzU1OTM4Y2M0&hl=en_US.

[17] Notes from the second meeting can be viewed at: http://www.cbhtr.org/bhept.

Regarding input:

- Regardless of model, there needs to be some mechanism for meaningful input from regions
- There must be more consumer, family, and provider involvement in policy development related to behavioral health
- Need to better reach out to consumers and provide opportunities for them to provide input in meaningful ways

Regarding money:

- Funding for behavioral health must be protected regardless of the model
- A greater percentage of dollars should be spent on services and a smaller percent on administration
- Regardless of structure, dollars saved through efficiencies need to go back into the system to build services for consumers

Regarding regionalization and cultural sensitivity:

- There is an awareness of the diversity within the state by region and by race/ethnicity and services must be culturally appropriate
- Any given model must recognize this diversity and be flexible enough to respond well across the state and to different populations
- There is a need for local/regional governance and administrative structures within any new model
- Some Local Collaboratives have worked better than others, been more inclusive, or had better consumer and regional representation. We should look at lessons learned to ensure that any local structures work to the best of their ability

Regarding local expertise:

- We have the expertise to do this in New Mexico ourselves rather than relying on outside (of state) expertise

- Need to incentivize care management, perhaps through per member per month payments
- Need to support services that promote co-ordination between emergency rooms and outpatient
- Need to protect specific services including psycho-social, transportation, supportive housing and employment, respite, and peer supports
- Need to incentivize services provided in rural areas perhaps through sub-capitation and/or enhanced rates and/or the use of different, rural area-specific service definitions
- There was an interest in performance contracting
- There was an interest in money following the individual
- There was an interest in using capitation rather than fee-for-service

There was not consensus across the groups regarding question 1 (Should behavioral health remain carved out, become carved in, or should a hybrid model be developed?). Rather several themes emerged. All groups supported their respective conclusion(s) by indicating that their model(s) would: 1) **best protect behavioral health funding.** (This, again, underscores the importance of managing and accounting for behavioral health monies separately), and that their model(s) would, or could, 2) **support improved integration of behavioral health and physical health services**.

Three groups[18] supported a "carved in" or "hybrid" model that would have behavioral health services administered by physical health Managed Care Organizations but with separate accounting for behavioral health dollars and accountability for behavioral health services. Presumably, this management arrangement for behavioral health services would also rely on existing behavioral health providers, provider networks and organizations. **Two groups[19] supported a "carved out" model.** (While there were only four groups, there were five positions as one group was split.)

There was a difference of opinion, too, on the number of organizations needed/desired to administer behavioral health. One group that supported services remaining carved out felt that

[18] N = 5 as one group was split between a "carve out" model and a "carve in" model.
[19] N = 5 as one group was split between a "carve out" model and a "carve in" model.

- Must be continued support for local and regional governance, involvement and decision making (voice)
- Local governance entities must be supported (e.g., LCs should have a paid coordinator)
- Must be transparent
- Mission, roles and expectations for all components of the governance structure (Collaborative, local entities, Planning Council, any others) must be clear
- Must be better at allowing for, structuring, and responding to consumer input
- The Planning Council should have more power; its relationship to local governance entities (LCs) should be strengthened and made more clear; and it should make recommendations for the use of reinvestment dollars

Conclusions and Next Steps

Although there was not consensus about the structure or governance for behavioral health in New Mexico, the following themes emerged:

- Improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected
- Regardless of model, we still need to address and improve integration of physical and behavioral health
- There must be transparency and accountability throughout the system to improve quality of care
- Regardless of model, there needs to be some mechanism for meaningful local and regional input into all aspects of the system
- There must be more consumer, family, and provider involvement in policy development related to behavioral health
- Funding for behavioral health must be protected regardless of the model
- A greater percentage of dollars should be spent on services and a smaller percent on administration
- Regardless of structure, dollars saved through efficiencies need to go back into the system to build innovative services for consumers
- The system must take into account the diversity of the state in terms of geography and race/ethnicity

Appendices

A) Behavioral Health Task Force Members and Affiliations

- **Steve Adelsheim**, M.D., Director, Consortium for Behavioral Health Training and Research at the University of New Mexico
- **Deborah Altschul**, Ph.D, Assistant Professor of Psychiatry, Consortium for Behavioral Health Training and Research at the University of New Mexico
- **Geri Cassidy**, Medical Assistance Division, New Mexico Humans Services Department
- **David J. Ley**, Ph.D, Co-Chair, New Mexico Youth Provider Alliance and Executive Director, New Mexico Solutions
- **Brent Earnest**, Deputy Secretary, NM Human Services Department
- **Sam Howarth**, Ph.D, Senior Policy Analyst, Robert Wood Johnson Foundation for Health Policy at the University of New Mexico.
- **Harrison Kinney**, Director, Behavioral Health Services Division, NM Human Services Department
- **Rodney McNeese**, Executive Director, Behavioral Health Finance, University of New Mexico Hospitals and President, New Mexico Providers Association
- **Diana McWilliams**, Deputy CEO, New Mexico Behavioral Health Collaborative
- **Karen Meador**, Policy Director, NM Behavioral Health Collaborative
- **Cathy Rocke**, Medical Assistance Division, New Mexico Human Services Division
- **Linda Roebuck-Homer**, CEO, NM Behavioral Health Collaborative
- **Shereen Shantz**, Program Manager for Consumer Affairs, New Mexico Behavioral Health Collaborative
- **Craig Sparks**, New Mexico Children, Youth and Families Department

Green Group (13)

- Bill Belzner
- Mickey Curtis
- Kayt Guttierez
- Beaver Northcloud
- David Graeber
- Patsy Romero
- Dolores Donihi
- Bette Betts
- Andrea Shije
- Deborah Clark
- Holly Spanks
- Gordon Eagleheart
- Diana McWilliams

Yellow Group (12)

- Rodney McNeese
- David Ley
- Nancy Jo Archer
- George Davis
- Gail Falconer
- Mike Estrada
- Shela Silverman
- Susan Casias
- Linda Mondy Diaz
- Lisa Sena
- Vincent D'Aloia
- Maggie McCowan